STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 10,792
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision of the Department of Social Welfare not to reimburse him for out of pocket expenditures for medications made during a period in which he was subsequently determined to have been eligible for Medicaid.

FINDINGS OF FACT

The parties have stipulated to the following facts and attached exhibits:

ORDER

The decision of the Department is affirmed.

REASONS

In the general scheme of the Medicaid program, payment for medical services are made directly to providers rather than recipients even when the recipients have already paid the bills. M ə 152. Exceptions are made for persons who were initially wrongfully denied but not for persons who paid bills while awaiting initial eligibility determinations. The regulations provide that:

> When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill

> Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the recipient's payment.
>
> M ə 152

The petitioner does not challenge the validity of this rule but seeks to avoid the operation of the above rule and to obtain reimbursement for the purchase of medications he made during his retroactive eligibility period but before he even applied for Medicaid by arguing that the Department failed in its duty to advise him of his obligation to apply for Medicaid thereby causing a delay in his eligibility determination. The petitioner's argument is essentially one of estoppel.

The Board has held in the past that estoppel against the Department is an extraordinary remedy which must meet the four elements established by the Vermont Supreme Court in Fisher v. Poole, 142 Vt. 162, 168 (1982):

> . . . first, the party to be estopped must know the facts; second, the party being estopped must intend that his conduct shall be acted upon or the acts must be such that a party asserting the estoppel has a right to believe it is so intended; third, the latter must be ignorant of the true facts; and finally, the party asserting the estoppel must rely on the conduct of the party to be estopped to his detriment.

In addition, when estoppel is asserted against a government agency which would prevent it from applying its own rules, the Board has adopted an additional criterion, set forth by the Supreme Court in Burlington Fire Fighters Assoc., et. al. v. City of Burlington, 149 Vt. 293 (1988), that the injustice is so great that it outweighs the public

interest in seeing the government carry out its usual obligations. Fair Hearings No. 9273 and 10,195.

In order to meet his burden in this case, the petitioner must show that the Department knew that he needed to file a new application to meet his spend down and was required to but failed to communicate that fact to him, and that the Department knew or should have known that the petitioner would likely file a new application or not in reliance on the information given to him. The petitioner must also show that he did not and could not reasonably have been expected to know that he had to file a new application with his spend-down documentation and that he in fact did not file a timely application and was thereby harmed. Finally, the petitioner must show that the injustice of having to pay $132.52 out of his own pocket for expenses which were subsequently covered by Medicaid is an injustice of a degree sufficient to bar the imposition of the no reimbursement rule.

Under the Department's rules, a written application is required before a determination can be made for Medicaid eligibility:

> Any individual who wants Medicaid must file a Medicaid application with the Department except:
>
> > An individual who has applied at a Social Security Office for Supplemental Security Income.
>
> If an individual granted SSI/AABD also wants retroactive Medicaid coverage before the start of the cash assistance grant, he/she must file a separate application for retroactive Medicaid coverage and be found eligible based on criteria other than receiving cash assistance.

> Filing an application means taking or mailing a signed Medicaid application form to a Department Office, preferable the District Office responsible for the town where the applicant lives. Department offices give Medicaid application forms to any individual who asks for one. Medicaid providers, referring agencies and other locations serving the public may also keep supplies of application forms.
>
> The application form must be signed by the individual applying for Medicaid or his/her authorized representative.
>
> M ə 111
>
> The regulations further provide that:
>
> Medicaid may be granted retroactively for up to three calendar months prior to the month of application, provided that all eligibility criteria were met during the retroactive period to be granted . . .
>
> M ə 113

There is no evidence to support a conclusion that the Department gave the petitioner erroneous information about his need to file an application in this matter, such as affirmatively advising him that he did not need to file an application or taking actions which could fairly be interpreted as so signifying. If the petitioner is to succeed in showing that the Department misled him, it would be because the Department had a further obligation to affirmatively advise the petitioner of the need for an application which it failed to do.

There is no question but that the petitioner has an obligation to affirmatively advise applicants for various welfare benefits as to their rights and obligations. Lavigne v. D.S.W., 139 Vt. 114 (1980), Fair Hearing No.

10,195. As the filing of a signed application is a prerequisite for eligibility determination (see M ə 111 above), the Department is bound to advise applicants of their duty to do so. See 42 C.F.R. ə 435.905. The issue, then, is whether the Department told the petitioner that he needed to file an application when he felt he met his spend down.

The notice sent to the petitioner in January, which closed his Medicaid case, did not explicitly state that he needed to file a new application. He was told by the Department, however, that his case was closed, that if his situation changed he should "let us know", that he "may" be eligible for Medicaid coverage if certain events occurred, and that he needed to "ask us to reconsider your eligibility."[1] That notice in essence directs the petitioner to recontact the Department when his situation changes.

In Fair Hearing No. 8342 the Board determined in a case involving notification of the operation of the ANFC lump-sum rules that it is not necessary to detail a rule in writing to a petitioner. What is essential, the Board concluded, is to communicate in writing to a disqualified recipient the importance of contacting the Department when certain changes occur. The Department is then required to communicate accurately to the petitioner what the petitioner's further rights and obligations are at that time.

The written notice given to the petitioner in this case could have easily said "you need to file a new application in the future". However, there is no reason why the worker could not orally inform the petitioner of this requirement as well. As in the ANFC case, as long as the petitioner was clearly told to contact the Department about future Medicaid eligibility upon the occurrence of any change, the notice should be sufficient, at least at the outset. Of course once the Department is contacted, it must then give out the correct detailed information.

In this case the Department was contacted when the change occurred by someone purporting to be a relative representing the petitioner. That person was clearly told of the need to file a new application and how assistance might be obtained in doing so. As the petitioner himself never called in and no one acting on his behalf including the representative of the Council on Aging, ever indicated to the Department that the relative did not represent him or that the petitioner needed forms, there was certainly no reason for the Department to know or suspect that the petitioner may have been unaware of this requirement or may have been unable to obtain the form. When the Department did receive an application for another program from the petitioner, it immediately used it to process his application in a manner which preserved his eligibility for the entire period claimed. It cannot be found on these facts, therefore, that the Department failed in its duty to

the petitioner.

Even if the Department should legally have done more in this case, there is no evidence from which it can be concluded that the petitioner or his representative was in fact unaware that he needed to file a new application. The stipulation provided by the parties only indicates that a written application was not filed until June 23, 1991. There is no indication as to why the petitioner had not filed the application before that time. There is not even an allegation in this case that the petitioner or his representative misunderstood the filing requirements.

In addition, although the petitioner may have suffered a real detriment (an out-of-pocket expense of $132.52) it cannot be said that the detriment was caused by any wrongful action of the Department or that the detriment was unusual or unjust. In spite of the delay in the filing of his application, the petitioner was still determined Medicaid eligible back to May 13, the first day of his hospitalization. Even if he had filed his application on May 13, there is no reason to suppose that Medicaid eligibility would have been immediately determined. The Department has thirty days to make a determination which in this case would involve verifying medical bills and doing calculations. The evidence shows that at this time the workers were very busy and running behind schedule about two weeks or more. (It took seventeen days to process the June 23 request.) It is very possible therefore that the

petitioner may have waited until mid-June to get a Medicaid card anyway.

In addition, expenditures for necessary medical bills, especially medicine often becomes necessary for applicants before eligibility can be determined and cards issued. Had the petitioner notified the Department of his need, he may have been found eligible for General Assistance or some other emergency program. However, there is no evidence that the petitioner notified the Department at any time as to his need. The petitioner has put forth no evidence in this case showing that the situation is so unique and unjust that the Department should be prevented from imposing its regulatory ban on reimbursements for all in the petitioner's situation.

Finally, the petitioner asserts that if he cannot be reimbursed for the $132.52 he spent, in the alternative he wants it to be applied to his next spend-down period which began September 1, 1991. The Department refuses to do so citing its regulations at M ɜ 414 and 443. Those regulations refer to spend-down calculations and direct that calculation for an eligibility period "include expenses incurred prior to the current period provided they have not been used in a previous accounting period to grant Medicaid and they were either paid in the current period or remain unpaid and continuing liability can be established". The $132.52 bill was obviously both incurred and paid in a period prior to September 1, 1991. The regulation clearly

prohibits that bill from being used to calculate the spend-down for the new period.

There being no reason to either except the petitioner from the ban on reimbursements for expenses paid prior to the establishment of eligibility or to apply the payments toward current spend-down requirements, the decision of the Department should be affirmed.

FOOTNOTE

[1]The petitioner was also apparently provided a pamphlet which further explained his rights and obligations which, unfortunately, neither party saw fit to place into evidence.

# # #